SUBSCRIBER CHANGE FORM

Please print clearly or type. Use this form for cancellations, changes, and other requests

Date Received

EMPLOYER SECTION

Company Name ______ Point of Contact ______

Phone ______ Fax ______ Email ______

HMSA Group ______ HMSA Band ______ Kaiser Group ______ Kaiser Band ______

EMPLOYEE INFORMATION

Employee Last Name ______ Employee First Name ______ MI ______ Suffix ______

CANCELLATIONS

Effective Date of Health Plan Cancellation
______ / ______ / ______

Last Day of Employment with your Company
______ / ______ / ______

☐ Cancel Employee Health Plan
Is the Employee electing COBRA? (check) ○ Yes ○ No

☐ Terminate Dependent(s)
List dependent(s) to be cancelled in the space below:
1) ______
2) ______
3) ______
4) ______
5) ______

Reason for Cancellation (Subscriber)
○ Standard Cancel
○ Death

Reason for Termination (Dependents)
○ Standard Cancel
○ Death

CHANGES

☐ Name Change new name--> ______
Attach documentation of Name Change

☐ Address Change new address--> ______
Include City, State, & Zip

☐ Phone Number Change new phone--> ______
Include Area Code

☐ PCP Change new PCP--> ______
Include Health Center Code & Full Name of PCP

OTHER REQUESTS

☐ Reissue HMSA Medical Card
☐ Reissue Kaiser Permanente Medical Card

AUTHORIZATION

Employer Signature ______ Date ______